Full Year and Q4 2021 Adaptimmune Earnings Conference Call

March 14, 2022

Corporate Speakers:

- Juli Miller; Adaptimmune Therapeutics plc; VP of IR
- Adrian Rawcliffe; Adaptimmune Therapeutics plc; CEO, Principal Accounting Officer & Director
- Dennis Williams; Adaptimmune Therapeutics plc; SVP of Late Stage Development
- Elliot Norry; Adaptimmune Therapeutics plc; Chief Medical Officer
- John Lunger; Adaptimmune Therapeutics plc; Chief Patient Supply Officer
- Helen Tayton-Martin; Adaptimmune Therapeutics plc; Co-Founder & Chief Business Officer
- Karen Miller; Adaptimmune Therapeutics plc; SVP of Pipeline Research
- Gavin Hilary James Wood; Adaptimmune Therapeutics plc; CFO

Participants:

- Marc Frahm; Cowen and Company, LLC; Analyst
- Paul Jeng; Guggenheim Securities, LLC; Analyst
- Nicholas Abbott; Wells Fargo Securities, LLC; Analyst
- Unidentified Participant; Unknown; Analyst
- Alexandre Bouilloux; Barclays Bank PLC; Analyst
- Unidentified Participant; Unknown; Analyst
- Jiayuan Gong; Mizuho Securities USA LLC; Analyst

PRESENTATION

Operator^ Good day. Thank you for standing by. Welcome to the Full Year and Fourth Quarter 2021 Adaptimmune Earnings Conference Call.

(Operator Instructions)

I would now like to turn the conference over to Ms. Juli Miller. Please go ahead, ma'am.

Juli Miller^ Good morning. and welcome to Adaptimmune's conference call to discuss our full year and fourth quarter 2021 financial results and business updates. I would ask you to please review the full text of our forward-looking statements from this morning's press release. We anticipate making projections during this call and actual results could differ materially due to several factors, including those outlined in our filings with the SEC. Adrian Rawcliffe, our Chief Executive Officer, is here with me for the prepared portion of this call. Other members of our management team will be available for Q&A. With that, I'll turn the call over to Adrian Rawcliffe. Ad?

Adrian Rawcliffe^ Thanks, Juli and thank you, everyone, for joining us. We filed our Form 10-K earlier today, and I'd like to recognize the team for their hard work enabling that to happen. Late in the process, we identified a material weakness in the operation and design of specific controls for the calculation of the valuation allowance against deferred taxation. This has no impact on our cash or cash runway. We have a plan in place to remediate this weakness, and I refer you to the 10-K for further details.

I'll begin the call today by laying out our focus for 2022, which ties into and will ensure delivery of the next stages of our 2-2-5-2 strategic plan. This year, we are focused on four main areas. Firstly, we intend to file our BLA for afami-cell for the treatment of synovial sarcoma in Q4 of this year. Secondly we will continue building on our MAGE-A4 franchise with the SURPASS family of clinical trials. Thirdly, with our Allogeneic platform, we are making progress towards filing our IND for our first wholly owned allogeneic product, targeting MAGE-A4 next year. And lastly, we are scaling up our manufacturing facilities to deliver cell therapies for our first commercial product and our ongoing and planned clinical trials, including this first allogeneic product.

I want to touch briefly on each of these and describe the progress we made last year and our plans for the coming year. The first focus area is filing the BLA for afami cell, our first-generation SPEAR T-cell product targeting MAGE-A4. In less than two years, against the backdrop of a global pandemic, we have successfully completed enrollment and treatment in Cohort 1 of the SPEARHEAD-1 pivotal trial, which will serve as the basis for the BLA. We've completed the efficacy analysis for Cohort 1. And as we shared during the JPMorgan conference, the trial has met its primary endpoint.

Further, at CTOS, we reported an overall response rate per independent review of 36% for patients in this heavily pretreated synovial sarcoma patient population. At the time of this data cut, the med duration of response had not been reached with 75% of the responders still in response. The nonclinical dossier for the BLA is complete and the pediatric plans have been agreed with the regulatory agencies. Going forward, we are working on additional elements required for the BLA filing, including supply of vector from Miltenyi Biotech's new facility, vector and T cell product characterization, method validation for the lot release assays, including our potency assays and completion of the clinical and CMC dossiers.

We are confident in our capabilities to deliver against these remaining elements, and we will report progress throughout the year. We are planning to present data from Cohort 1 of the SPEARHEAD-1 trial at ASCO and as well as combined data from Cohorts 1 and 2 at CTOS.

The second focus area for 2022 is to continue building our MAGE-A4 franchise with the SURPASS family of trials using our next-generation ADP-A2M4CD8 SPEAR T-cells targeting MAGE-A4. At ESMO last year, we presented data from our Phase I SURPASS trial in multiple solid tumor indications. We reported an overall response rate of 36% with a confirmed complete response in ovarian cancer and confirmed partial responses in ovarian, head and neck, esophagogastric junction and bladder cancers as well as synovial

sarcoma. Based on these and earlier data, we initiated recruitment in a Phase II trial SURPASS-2 for people with esophagogastric junction or esophageal cancers. And we will initiate another Phase II trial SURPASS-3 for people with ovarian cancer this year.

The SURPASS Phase I trial continues to enroll, focusing on patients with gastroesophageal, head and neck, lung, bladder and ovarian cancers. And we'll add an arm to this trial to combine our SPEAR T cells with a checkpoint inhibitor. We plan to present data from the original protocol of the Phase I SURPASS trial at ESMO this year.

The third focus is our allogeneic program. We are the only company in our space with advanced autologous cell therapy trials as well as a stem cell-derived allogeneic T-cell platform. Autologous therapies are critical for near- and medium-term value creation and they provide learnings that will drive the long-term success with our Allogeneic platform. We've demonstrated in our Allogeneic platform that we can produce T-cells from stem cells that kill cancer cells in vitro, and do so in a serial fashion. We plan to file an IND for our wholly-owned allogeneic sales targeting MAGE-A4 next year, and we're become -- building a dedicated allogeneic manufacturing facility in the U.K.

Last year, we announced our strategic collaboration with Genentech to research, develop and commercialize allogeneic cell therapies. This collaboration covers development of products but to five shared cancer targets as well as a novel allogeneic personalized cell therapy platform. The collaboration has initiated, and we received a $150 million upfront payment in Q4 last year as reflected in our financials.

The last focus area for 2022 is to add scale to our CMC capabilities. Our 2-2-5-2 strategy is underpinned by our integrated cell therapy capabilities. I don't think it's controversial to say that to be successful as a cell therapy company, you need strength and depth across manufacturing and supply chain. And we've been consistently thoughtfully investing in our CMC capacity for more than seven years, and have built an impressive set of capabilities. We've produced hundreds of batches of cell therapy for our autologous clinical trials with multiple products across a broad range of tumors. The GMP manufacturing capabilities at the Navy Yard are now being expanded to meet the needs of our first commercial product as well as our ongoing and planned late-stage clinical trials. We've begun construction of an additional manufacturing facility in the U.K. for allogeneic therapies.

And finally, our in-house vector manufacturing in the U.K. has been successfully running for about two years now. At Adaptimmune, we are motivated by a shared mission and vision to transform the lives of people with cancer by designing and delivering cell therapies. As part of that commitment, we've bolstered our internal teams. We appointed Cintia Piccina as Chief Commercial Officer in January. Cintia has deep experience in oncology and in particular, with cell therapy. She will be a great champion of our products, and the BLA this year is only the beginning of our ambitions here.

We also hired Irving Ford as our Head of Quality. We previously worked on delivering marketed cell therapy products at both Novartis and BMS.

In conclusion, we have seen the power of T cells to treat cancer. As shown in our own engineered TCR T cells and also CARTs, TILs and checkpoint inhibitors. We have taken an ambitious path to develop cell therapies for difficult-to-treat solid tumors and it is extremely gratifying and motivating to hear about the impact of our cell therapies have in conversations with our investigators and the people they treat. We are leading the way in engineered TCR T-cell therapies for cancer, and we are on the verge of filing our first BLA, which if approved, will be the first engineered TCR T cell therapy on the market. we're well funded into early 2024 to deliver on our objectives.

And with that, I'd like to open it up for questions. Operator?

QUESTIONS AND ANSWERS

Operator^ (Operator Instructions)

Our first question comes from the line of Marc Frahm with Cowen.

Marc Frahm^ Maybe just start off, Adrian, you listed a handful of different kind of elements of the CMC dossier that need to be completed over the next couple of quarters to get the BLA submitted in Q4. Which of those you can view as the rate limiting step to the CMC dossier or are they all kind of on the same path?

Adrian Rawcliffe^ So I'm going to ask Dennis Williams, who's leading -- who leads our late-stage development of a pharma cell to comment on that Marc.

Dennis Williams^ Sure. Thanks, Marc. So I think some of those -- the activities for T cell process performance qualification, prerequisite to be complete, meaning things like assay method validation, you need to have your commercial vector in hand. So I wouldn't necessarily categorize one versus another is in rate limiting, but the T cell PPQ essentially is the last step in the chain where you need to complete those prerequisites first. So chronologically, it is the less activity to occur prior to finalizing Module 3 of the BLA.

Marc Frahm^ Okay. That's helpful. And then maybe just with experience of the team having filed some other work towards commercialization, filing of some other cell therapies. If you compare contrast to the assays that you need to kind of fully validate here to what's been done with some other cell therapies have successfully developed and then maybe also with what we've seen go on in the TIL space?

Dennis Williams^ Sure. This is Dennis Williams again. So many of these assays were validated prior to the QC even in Phase II trials, including SPEARHEAD-1. Now as we look towards commercialization, we'd like to tighten these assays and further optimize. So these are the method validations that I'm speaking about that we're -- these are an ongoing process now for this dossier. I think maybe you're alluding to potency assays.

And I think for what we do, that we use an antigen-specific for the toxicity assay, right? So I think our circumstance for potency is quite different from what one may see in the TIL therapy. We have been using the same set of toxicity assay prior to the start of SPEARHEAD-1. So hopefully, the -- I don't know if I addressed your question or not.

Operator^ Your next question is from Michael Schmidt from Guggenheim.

Paul Jeng^ This is Paul on for Michael. First one is just quickly, could you provide some guidance on how many additional patients yet on the SURPASS trial at ESMO this year?

And then secondly, there was some data last year from Immunocore bispecific targeting MAGE-A4 with somewhat different enrollment criteria in terms of expression. Wondering if you could just talk about differentiation from your approach, maybe how you view coming updates from that program relative to your MAGE-A4 franchise?

Adrian Rawcliffe^ Thanks. So I'll truncate. We've not been specific about the number of patients but we anticipate that it will be a significant update, and that's all we've said about patients. With respect to the differentiation of our cell therapy from Immunocore's bispecific and other matters, I'll ask Elliot to comment on that.

Elliot Norry^ Yes, I'll just add that with respect the update that's anticipated at ESMO, we do anticipate that it will be across tumor types. With respect to the Immunocore data, I mean, I think there was a publication earlier this year where they made initial data public. And their approach to antigen expression was really quite different from ours. And in addition to that, the data that they presented was really very early. So I think it's really premature to make broad comparisons.

We're pretty rigorous about ensuring that patients who come into the trial have a known level of antigen expression. And that helps us with respect to interpreting the results. I think that at least our takeaway from the information that was published by Immunocore was that for some of their tumor types, they did not require antigen expression measurements prior to entering the trial and then did that retrospectively. And they also saw some responses with what they described as very low levels of expression, although the durability of those responses was not very well. I just don't think they've had enough time to be able to fully describe it in the early publication.

So the bottom line is that I think there's a long way to go as it relates to making comparisons. I mean, I think we'll stand behind our data with a clear definition of antigen expression and a RECIST response rate of 36% in very advanced patients with multiple tumor types.

Operator^ Next is from Nick Abbott from Wells Fargo.

Nicholas Abbott^ Well, first Ad, in terms of the expansion in the Navy Yard. Can you talk about sort of what percentage increase in capacity on the current capacity that you're targeting there? And presumably, this is going to come online following a BLA approval?

Adrian Rawcliffe^ Yes. So I'll ask John Lunger, our Chief Patient Supply Officer, to comment on that. John?

John Lunger^ Yes. Thanks for the questions. So yes, the current capacity we have at the facility is around about 300 or so patients a year. And when I talk about capacity, I'm talking about room and equipment, and then when I say current capacity, I mean we have the staffing available to do that. The expansion in the Navy Yard will bring us up to a theoretical capacity of 600 to 700 patients per year out of that facility, which is a combination of clinical supplies for future autologous products as well as commercial for afami-cel. So we obviously will need to staff that. We are looking to have the rooms complete and ready to move manufacturing in later on this year.

Nicholas Abbott^ Great. Appreciate the detail. And then I had to join late, apologies if you addressed this, but -- so can you talk about a companion diagnostic for HLA MAGE-A4 or will they just get kind of rolled into current of NGS style diagnostics?

Adrian Rawcliffe^ I'll ask Dennis to comment on that, Dennis?

Dennis Williams^ Yes, sure. So I'll take MAGE-A4 first. So we are developing with a companion diagnostic manufacturer Agilent that they are developing a commercial MAGE-A4 IHC test. And we -- that premarket application or PMA is planned to be scheduled -- it is planned to be submitted contemporaneously with the BLA. So that will be the diagnostic companion that will -- patients for afami-cel will be selected in the commercial setting.

For HLA, we use a 510(k) cleared test presently. It's sequencing and that is likely to be the test that people will use in the commercial setting. Your comment is well taken about NGS. I'm quite aware that the field is moving on with new technologies for HLA testing. But at the moment, we use in trials a (inaudible) sequencing test for HLA.

Nicholas Abbott^ Sure. And then last one for me. And it goes to, obviously, when you selected the sarcoma subtypes because we had very high expression from MAGE-A4, but there is a sprinkling of MAGE-A4 is presuming in other sarcoma subtypes. So do you think there would be any interest when you speak to physicians as an interest for evaluating this in other sarcoma subtypes that may have lower levels of MAGE-A4 that you see in the two that you selected so far?

Dennis Williams^ Yes. This is Dennis Williams. That's a good question. And we are evaluating -- continue to evaluate these expression levels of MAGE-A4 in other sarcoma subtypes, as you mentioned. Sarcoma as a disease is very heterogeneous and there are many different subtypes. Of note, like, for example, we certainly are looking to evaluate whether or not any of the sarcomas that occur in children with express MAGE-A4 as we consider pediatric plans. But some of that will have -- at the end of the day, will be dictated on how much expression level there is and how some sarcoma subtypes are even

rare than the set -- than myxoid liposarcoma or synovial sarcoma. So that's something we're continuing to evaluate at this point in time.

Operator^ Next, we have Jonathan Chang from SVB Leerink.

Unidentified Participant^ This is (inaudible) on for Jonathan Chang. I just had a question on SURPASS-3, if you had any updated thoughts or guidance on what the ideal patient population is within ovarian cancer for the SPEAR T-cell approach?

Adrian Rawcliffe^ So maybe I'll just take that one very quickly. The patients treated in SURPASS-1 are platinum ineligible patients. And we probably anticipate that the SURPASS-3 trial will recruit into a similar population.

Unidentified Participant^ Got it. And then for SURPASS-2, does prior PD-1 have an effect on the activity of SPEAR T-cells? And does this inform the trial design anyway?

Adrian Rawcliffe^ Elliot?

Elliot Norry^ Yes. So I think that the impact of prior checkpoint inhibition with respect to T cell therapy is one that we're continuing to evaluate. In that patient population, the vast majority of patients going forward are likely going to have received checkpoint inhibitor as part of their first-line therapy. So we're specifically aiming to study that population. It actually allows us an opportunity to potentially treat patients -- some patients in second line as compared to after the sequence of chemotherapy followed by checkpoint inhibitors. Those patients often get them in combination.

So I think that the data will have to bear itself out. But in the realm of treating a range of solid tumors in late stage, we're certainly gaining plenty of experience of dosing patients who have already received checkpoint inhibitor. That doesn't preclude that they couldn't benefit from further use of checkpoint inhibitor with -- in combination with T cell therapy, and we're going to be exploring that as well. Adrian mentioned earlier that we're opening an arm of the SURPASS trial, the Phase I SURPASS trial to look at T cells in combination -- our SPEAR T-cells in combination with checkpoint inhibition.

Operator^ Next question is from Peter Lawson with Barclays.

Alexandre Bouilloux^ This is Alex on for Peter. Just on the Genentech collaboration. I was just curious what we should expect to learn from this over the next year or so maybe in terms of targets to any time to disclose that?

Adrian Rawcliffe^ I'll ask Helen to answer that for you.

Helen Tayton-Martin^ Yes. So we haven't disclosed the target selected by Genentech, and there isn't actually an intention to do that. What we have talked about is there are research milestones, which we will continue to track through, which come as part of that deal. So I think really, that's probably where we will be updating on the market. It will be

to progress come through those committed payments. So that's -- but all I can say is it's kicked off well, and it started well. So we're really pleased with progress so far.

Operator^ We have a question from Soumit Roy from JonesTrading.

Unidentified Participant^ This is (inaudible) for Soumit Roy. It's for SURPASS SPEARHEAD-1, about the Cohort 2 that you expect to update data in ASCO is upon positive -- do you expect to submit the data also to support the BLA?

Adrian Rawcliffe^ I'll ask Dennis to highlight data that we'll be presenting at ASCO and CTOS and how Cohort 1 and Cohort 2 will be used in the BLA. Dennis?

Dennis Williams^ Yes, sure. So yes, for ASCO, actually Cohort 2 data is not planned to be presented. For ASCO, there are plans to present data that's actually pulled from our Phase I experience in sarcoma as well as the data from Cohort 1 SPEARHEAD-1 in the final data set. So this is data that's more mature than what was presented at CTOS. And that will really focus in on areas about where -- of areas that may be interesting from that may impact efficacy. So stay tuned for that, that will be something we've submitted for ASCO. At CTOS or we're targeting to have data from both Cohort 1 and Cohort 2 presented.

To answer your question about the BLA, Cohort 1 is the primary data set that is intended to be in the BLA. And that is what the clinical documents are being written around. Ultimately, for the BLA, we will have to update as required, something that's known as the safety update and in Cohort 2 data would be utilized for that data. But Cohort 2 data is not planned to be included from an efficacy perspective.

Operator^ (Operator Instructions)

We have a question from Mara Goldstein from Mizuho.

Jiayuan Gong^ This is Jerry Gong on for Mara. The first one is for the single center study of the TIL program. Can you give us some more details on which indications the company may be focusing on?

Adrian Rawcliffe^ Certainly, I'll ask Karen to answer that. Karen's been leading the TIL efforts to date.

Karen Miller^ Yes, of course, this is going to be a single center study working in partnership with (inaudible) at the CCIT in Denmark, and we are targeting melanoma with a TIL product that is enhanced by the secretion of Interleukin-7.

Jiayuan Gong^ Got you. And for the finances, I believe the current guidance is for 2024 which should include some milestones, how much of the current runway guidance includes these milestones?

Gavin Wood^ It's Gavin, the CFO. We have broken it out in detail, but we're reiterating guidance to early '24.

Operator^ There are no further questions at this time. I would now like to turn the conference back to Mr. Adrian Rawcliffe.

Adrian Rawcliffe^ Thanks. And thanks, everyone, for your time and your questions today. I look forward to updating you throughout 2022 as we track towards the BLA for the first-ever engineered TCR therapy afima-cel for synovial sarcoma. Thanks, and have a great day.

Operator^ This concludes today's conference call. Thank you for joining. You may now disconnect.